Initial Approval: October 11, 2017

CRITERIA FOR PRIOR AUTHORIZATION

Motofen® (difenoxin/atropine)

PROVIDER GROUP Pharmacy

MANUAL GUIDELINES The following drug requires prior authorization:
Difenoxin/Atropine (Motofen®)

CRITERIA FOR APPROVAL (must meet all of the following):

- Patient must have tried and failed diphenoxylate/atropine (Lomotil)
- Patient must be 12 years of age or older
- Dose must not exceed 8 tablets per day
- Treatment duration does not exceed 48 hours
- Diagnosis is not attributable to diarrhea associated with organisms that penetrate the intestinal mucosa (e.g. toxigenic E. Coli, Salmonella spp, Shigella) and pseudomembranous colitis associated with broad-spectrum antibiotics

LENGTH OF APPROVAL: 1 fill

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DRUG UTILIZATION REVIEW COMMITTEE CHAIR	PHARMACY PROGRAM MANAGER DIVISION OF HEALTH CARE FINANCE KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
_____	_____
DATE	DATE